

Riverside County Children Services Specialized Care Proposal

Rationale

In accordance with All County Letter 18-48 "State Guidance for Specialized Care Rate (SCR) Programs," Riverside County Department of Public Social Services, Children Services Division (CSD) proposes a new Special Care Increment (SCI) tool and rate levels to align with the implementation of the Continuum of Care Reform Level of Care (LOC) Protocol.

This document outlines our proposed SCI tool and rate levels.

1. Characteristics and Number of the Current and Proposed SCI Population

Riverside County CSD is currently providing SCI funding to 190 children in licensed county foster family, resource family (RF), relative and non-related extended family member (NREFM) homes, including guardianship homes. The following describes characteristics of these children, but is not all inclusive:

- Physical conditions: feeding issues, self-care deficits, blood or genetic disorders, diabetes, terminal illness, infant drug exposure, neurological issues, cardiac issues, infectious diseases, respiratory issues.
- Emotional/Behavioral conditions: attention deficit and/or hyperactivity, truancy, gang involvement, destructive and/or aggressive behaviors, self-mutilation, attempted self-injury, suicidal ideation, fire-starting, cruelty/harm to animals, sexual acting out behaviors, attachment issues or separation anxiety, drug or alcohol use/abuse, recent history of mental health, Autism, Reactive Attachment Disorder (RAD), Conduct Disorder, Oppositional Defiant Disorder (ODD), Obsessive Compulsive Disorder (OCD).

The extra care and supervision warranted on behalf of these characteristics is largely captured by the LOC Protocol. We anticipate including medically-fragile children placed through FFAs, representing a possible increase in caseload of 60 children.

2. Payment Amounts and Tiers

Riverside County's current system is based on form CSD 4100, a matrix similar to the LOC 501, with rates ranging from \$100 to \$1,100.

Riverside County's proposed system would utilize form CSD 4093 SCI Assessment and Approval, which provides three tiers with rate increments of \$150, \$500 and \$800.

3. Criteria for Each Tier of the Proposed System

The criteria for each tier is provided on form CSD 4093, and was the result of an in-depth comparison of our CSD 4100 and the LOC 501, to eliminate conditions already determined to be adequately represented by the LOC 501.

4. County Review Process

Children currently receiving SCI funding will be re-assessed under the new process to ensure all the child's care and supervision needs are fully addressed when their SCI reassessment is due. If the social worker completes an LOC determination for the child, he or she will review and adjust the child's SCI as appropriate.

New form CSD 4093 eliminates the use of several previous forms to further streamline the process. The following table provides an overview of Riverside County's proposed SCI process:

Stage	Description
1	The social worker: <ul style="list-style-type: none"> • completes form CSD 4093 with the caregiver and • sends it to his or her supervisor for review.
2	The supervisor reviews the determination and: <ul style="list-style-type: none"> • consults with the social worker if he or she has concerns with the determination, or • approves the CSD 4093 if he or she is in agreement with the rationale and level, and • forwards it to the designated county staff for approval/data entry, or • forwards it to the manager for additional review and approval if required by the proposed level.
3	The designated county staff reviews the CSD 4093 and either approves or denies the SCI.
4	If the SCI funding/funding increase is denied, the caregiver receives: <ul style="list-style-type: none"> • Form CSD 4094 Special Care Increment Outcome Letter • State form PUB 13 "Your Rights Under California Welfare Programs."
5	If the SCI funding is approved/increase/decreased/discontinued: <ul style="list-style-type: none"> • Foster Care Eligibility staff receive forms: <ul style="list-style-type: none"> ○ CSD 4093, and ○ SOC 158A.
6	Foster Care Eligibility: <ul style="list-style-type: none"> • enters the SCI funding rate into C-IV to authorize the payment, and • issues a Notice of Action regarding the funding rate to the caregiver with the SCI rate amount specified.
7	This process is repeated at each six-month reassessment.

5. Circumstances Which Trigger an SCI Assessment

The social worker completes an SCI assessment when:

- the social worker determines the level of care and supervision the child requires exceeds the established LOC rate, or
- whenever a caregiver makes a request.

An SCI may be re-determined in between the scheduled six-month reassessment if:

- the child moves from one placement to another, based on the caregiver's willingness and ability to provide increased care and supervision or
- when the child's care and supervision needs appear to have changed.

6. Proposed Implementation Plan and Date

Riverside County CSD will proceed with training social workers following plan approval and caregiver notification. The new process will be used after the completion of training, at the earlier of:

- the due date for the current SCI reassessment, or
- completion of the child's LOC determination, if the SW deems necessary.

If a child receiving an SCI has a triggering event, the social worker will complete the LOC determination and then assess whether the child's SCI requires a modification.

7. Notification to Caregivers

Riverside County will provide an announcement to current caregivers upon plan approval, specifying implementation no earlier than 30 days from the date of notification.

8. Notices of Action (NOAs)

Riverside County will provide a NOA to a caregiver when the child receives an SCI assessment, to advise whether the SCI was:

- approved or denied following an initial assessment, or
- increased, decreased or remained the same following a reassessment.

When the child's rate increases or decreases following an SCI assessment/reassessment, the C-IV system issues a NOA to the caregiver. When the child's rate remains the same following an SCI assessment/reassessment, the social worker will provide NOA form CSD 4094 SCI Outcome Letter (attached) to the caregiver specifying that the child did not qualify for an SCI or did not qualify for an increase, and providing the formal State hearing information on the reverse.

9. County SCI Point of Contact (POC)

Chris Rosselli will serve as the Riverside County SCI POC. His information is as follows:

Chris Rosselli, Regional Manager
(951) 358-3225 (office)
(951) 358-4349 (fax)
11070 Magnolia Ave. Suite B
Riverside CA, 92505

Riverside County CSD expects that this proposed change will:

- ensure each child who continues to qualify for SCI funding receives a funding rate that accurately aligns with the LOC Protocol
- provide appropriate additional assistance to allow children to be placed in the least restrictive level of care possible
- promote placement stability, and ensure quality care, and
- streamline processes to best conserve workforce efforts.



Riverside County Department of Public Social Services – Children’s Services Division
Special Care Increment and Emergency Placement ACF Worksheet – DPSS 4100

Social Worker's Name:	Date of the SCI Assessment:
Child/Youth Name:	Date of Birth:
Caregiver's Name:	Date Child/Youth Was Placed in the Caregiver's Home:
Caregiver's Address (street address, apt no., city, state, and zip code):	
Caregiver's Home Phone Number: ()	Caregiver's Cell Phone Number: ()

PLEASE CHECK ONE: INITIAL SCI ASSESSMENT REASSESSMENT

Is child a Regional Center client? Yes No

Note: A Regional Center client/child cannot receive a SCI and a dual agency rate. Generally, the dual agency rate is higher than the Special Care Rate (SCR).

*****THIS FORM IS RESTRICTED FOR USE BY THE CPU/SPECIAL CARE INCREMENT UNIT*****

PHYSICAL/HEALTH DISABILITY

Name of Child/Youth:	Date of Birth:		
Qualifying Condition - Non-EMS: (Check all that apply, regardless of steps).			
<input type="checkbox"/> Feeding Issues	<input type="checkbox"/> Artificial Openings	<input type="checkbox"/> Self-Care Deficits	<input type="checkbox"/> Blood or Genetic Disorders
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Drug Exposed Infant	<input type="checkbox"/> Neurological Issues
<input type="checkbox"/> Cardiac Issues	<input type="checkbox"/> Infectious Disease(s)	<input type="checkbox"/> Respiratory Issues	<input type="checkbox"/> Surgical/Fractures/Burns Wound Care
<input type="checkbox"/> Obesity	<input type="checkbox"/> Pregnancy		
<input type="checkbox"/> Other physical/health disability issues not otherwise specified--explain: _____ (Requires SCI Supervisor approval): _____			

INCREMENT	CHILD/YOUTH REQUIREMENTS
\$100	<input type="checkbox"/> Child/youth requires additional care and supervision due to a medical condition of obesity as diagnosed by a medical professional, whose treatment plan includes one or more of the following: regular monitoring by a medical professional over and above age-appropriate check-ups, completion of specific goals identified by professionals (i.e. medical professional, nutritionist, staff of weight management program appropriate to child's/youth's age), adhering to at least the minimum doctor recommended minutes a day of extra-curricular physical activity, and family-oriented education regarding the benefits of regular physical activity. <input type="checkbox"/> Child/youth requires specialized feeding techniques as recommended by a medical professional (such as for a cleft lip/palate, poor suck/swallow coordination, etc.). <input type="checkbox"/> Child/youth has visual deficits and requires a sighted guide outside the home <input type="checkbox"/> Child/youth requires postural supports and frequent repositioning <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
\$150	<input type="checkbox"/> Child/youth requires frequent feedings (more than 6 times per day or more than 30 minutes each) <input type="checkbox"/> Child/youth uses a recognized sign language (such as ASL, SEE, PSE, etc.) or relies on the use of a communication board <input type="checkbox"/> Child/youth requires a sighted guide at all times (inside and outside home) <input type="checkbox"/> Child/youth requires intermittent use of an apnea monitor, nebulizer, or asthma inhaler <input type="checkbox"/> Child/youth requires post surgical care and treatment as ordered by a physician <input type="checkbox"/> Child/youth requires daily adaptive therapy exercises or the use of adaptive equipment in the home <input type="checkbox"/> Child/youth has a history of terminal illness that is in remission – follow-up for this condition to be no more than 3 times a year, as recommended by a physician <input type="checkbox"/> Child/youth requires additional care and supervision due to a medical condition of pregnancy as diagnosed by a medical professional, requiring supervision by the caregiver to ensure the child/youth attends monthly check-ups/other scheduled medical appointments and parenting/childbirth classes, as well as providing for increased nutritional needs as prescribed by a medical professional for the duration of the pregnancy. <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
\$200 (ENTER SCI FFA SPECIAL PROJECT CODE)	<input type="checkbox"/> Child/youth is incontinent and over the age of 4, necessitating purchase of diapers and supplies, frequent washing of linens, extra linens, etc. <input type="checkbox"/> Child/youth requires increased care and supervision due to severe self-care deficits in the areas of grooming, bathing, hygiene, and dressing- but child/youth can provide some assistance such as raising arms to dress <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
\$250 (ENTER SCI FFA SPECIAL PROJECT CODE)	<input type="checkbox"/> Child/youth relies on Braille or Tactile Sign Language to communicate <input type="checkbox"/> Child/youth requires the use of an apnea monitor, nebulizer, or asthma inhaler more than 4 times daily <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

Qualifying Condition--Severe Medical Problems or EMS/Medically Fragile: These rates apply to a child/youth who has been screened through the Interagency Placement Screening Committee (IPSC) and found to meet the criteria for the Enhanced Medical Services (EMS)/Medically Fragile Program, OR to a child/youth with severe medical problems but deemed by the IPSC or EMS PHN as not appropriate for EMS. Please attach documentation to support level of care. (Check all that apply, regardless of steps).

<input type="checkbox"/> Feeding Issues	<input type="checkbox"/> Artificial Openings	<input type="checkbox"/> Self-Care Deficits	<input type="checkbox"/> Blood or Genetic Disorders
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Drug Exposed Infant	<input type="checkbox"/> Neurological Issues
<input type="checkbox"/> Cardiac Issues	<input type="checkbox"/> Infectious Disease(s)	<input type="checkbox"/> Respiratory Issues	<input type="checkbox"/> Surgical/Fractures/Burns Wound Care
<input type="checkbox"/> Obesity	<input type="checkbox"/> Pregnancy		

Other serious physical/health disability issues not otherwise specified - provide a detailed description: (Requires SCI Supervisor approval): _____

CHILD/YOUTH REQUIREMENTS

INCREMENT	
*\$667 RM APPROVAL REQUIRED (ENTER SCIMED FRAGILE SPECIAL PROJECT CODE)	<input type="checkbox"/> Child/youth requires an accessible environment due to the use of a wheelchair at all times (home must be WC accessible) <input type="checkbox"/> Child/youth requires weekly wound care or post-surgical care, as ordered by a physician <input type="checkbox"/> Child/youth requires constant swaddling and comfort due to a specific medical condition such as prematurity, drug withdrawal, failure to thrive, etc. <input type="checkbox"/> Child/youth on medication requires daily monitoring of vital signs in accordance with physicians' orders <input type="checkbox"/> Child/youth with diabetes requires daily blood sugar monitoring and the corresponding treatment/interventions, including insulin injections, oral medication, etc. <input type="checkbox"/> Child/youth with seizure disorder requires daily oral medication. <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
*\$811 ↓ RM APPROVAL REQUIRED	<input type="checkbox"/> Child/youth has exceptional medical feeding needs (such as NG tube, TPN, high frequency) <input type="checkbox"/> Child/youth requires a modified home environment to accommodate his/her needs (severe food allergies, etc.) <input type="checkbox"/> Child/youth has physical/health disability needs that limit/prevent the SCP from utilizing respite services <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
*\$956 ↓ RM APPROVAL REQUIRED	<input type="checkbox"/> Child/youth with a severely compromised immune system requires a safe and sterile environment <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____
*\$1100+ ↓ DD APPROVAL REQUIRED	<input type="checkbox"/> Child/youth has a terminal illness or is on hospice, and requires frequent medical treatments (such as radiation, IV chemotherapy, or palliative care) for end of life issues <input type="checkbox"/> Child/youth is ventilator dependent or requires constant suctioning to maintain an open airway, necessitating constant supervision and care <input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____

APPROVALS: Original signatures are not required on the DPSS 4100 if a supervisor, manager or a deputy director is forwarding an approved request via CWS/CMS email and indicates electronic approval on the form and in the email.

Placement RM Approval:	By:	<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	Date:
Deputy Director Approval:	By:	<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	Date:

Continued on next page

EMOTIONAL/BEHAVIORAL, continued

*** NOTE:** The rates below on this page require Placement Regional Manager or Deputy Director approval.

Qualifying Condition--The emotional/behavioral rates below apply only to a child or youth who has been screened through the Interagency Placement Screening Committee (IPSC) and found to meet the criteria for this level of SCI. (Check all that apply, regardless of steps).

INCREMENT	CHILD/YOUTH REQUIREMENTS, continued
<p>* \$800 RM APPROVAL REQUIRED (ENTER SCI GH SPECIAL PROJECT CODE)</p>	<p><input type="checkbox"/> Child/youth with severe emotional/behavioral issues, requires constant direct care and supervision during waking hours to keep the child/youth or others safe</p> <p><input type="checkbox"/> Child/youth has severe emotional/behavioral problems which prevents the SCP from obtaining respite care</p> <p><input type="checkbox"/> Child/youth has severe emotional/behavioral problems and requires regular intervention through ETS, Therapeutic Behavioral Service (TBS) or Wraparound Services</p> <p><input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____</p>
<p>* \$1100+ DD APPROVAL REQUIRED (ENTER SCI GH SPECIAL PROJECT CODE)</p>	<p><input type="checkbox"/> Child/youth requires constant and direct care and supervision (24 hours per day) due to Mental Health challenges-these include severe and chronic illnesses that are expected to result in mental/emotional impairment that cannot improve through medication, support or behavioral modification; and/or requires continuous supervision beyond what would be considered age appropriate</p> <p><input type="checkbox"/> Child/youth has escalated acting out behaviors and may qualify for group home placement if a lower level of care (least restrictive placement) cannot be located</p> <p><input type="checkbox"/> Other - explain: _____ (Requires SCI Supervisor approval): _____</p>

APPROVALS: Original signatures are not required on the DPSS 4100 if a supervisor, manager or a deputy director is forwarding an approved request via CWS/CMS email and indicates electronic approval on the form and in the email.

Placement RM Approval:	By:	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Date:
Deputy Director Approval:	By:	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Date:

Continued on next page

30-DAY EMERGENCY PLACEMENT-ACF (PAID OUT OF ALL COUNTY FUNDS)

Qualifying Condition - One-time Emergency Placement: (Check all that apply, regardless of steps).	
Is the child/youth placed in a licensed foster home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child/youth being placed meet SCI Qualifying Conditions for at least one of the <i>primary domains</i> (the physical/health disability domain or emotional/behavioral domain)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the child/youth require "emergency placement" (between 5:00PM and 7:00AM, or on weekends or holidays)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this placement the child's/youth's initial placement of the placement episode?	<input type="checkbox"/> Yes <input type="checkbox"/> No

TIME OF PLACEMENT	CHILD/YOUTH REQUIREMENTS
<ul style="list-style-type: none"> • 5:00PM - 10:00PM 	<ul style="list-style-type: none"> <input type="checkbox"/> Child/youth requires emergency placement between 5:00PM – 10:00pm <input type="checkbox"/> Child/youth may require transport to the doctor or a CAN exam, at the request of the social worker <input type="checkbox"/> Child/youth may require a clothing purchase within 24 hours of placement <input type="checkbox"/> Child/youth may require a meal upon placement, if the child/youth is hungry
<ul style="list-style-type: none"> • LATE NIGHT • EARLY MORNING BEFORE 7:00AM • HOLIDAYS & WEEKENDS 	<ul style="list-style-type: none"> <input type="checkbox"/> Child/youth requires emergency placement after normal business hours, on the weekend, or on holidays <input type="checkbox"/> Child's/youth's emergency placement requires the SCP to be available by telephone 24/7 <input type="checkbox"/> Child/youth may require transportation to the doctor or a CAN exam, at the request of the social worker <input type="checkbox"/> Child/youth may require a clothing purchase within 24 hours of placement <input type="checkbox"/> Child/youth may require a meal upon placement, if the child/youth is hungry

ONE-TIME ACF APPROVAL: Original signatures are not required on the DPSS 4093 if a supervisor, manager or a deputy director is forwarding an approved request via CWS/CMS email and indicates electronic approval on the form and in the email.	
Placement RM Approval:	By:
<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved	Date:

<input type="checkbox"/> LEVEL I Mild Need(s)	<input type="checkbox"/> LEVEL II Moderate Need(s)	<input type="checkbox"/> LEVEL III Intensive Need(s)
Rate: \$150.00	Rate: \$500.00 RM Approval Required	Rate: \$800.00 DD Approval Required
<u>Criteria</u>	<u>Criteria</u>	<u>Criteria</u>
<input type="checkbox"/> Child/NMD age 7 years or older has night-time enuresis necessitating purchase of diapers and supplies, extra linens, frequent washing of linens at least three (3) times per week, and so on <input type="checkbox"/> Child/NMD is incontinent and over the age of 4, necessitating purchase of diapers and supplies, extra linens, frequent washing of linens at least three (3) times per week, and so on <input type="checkbox"/> Child/ NMD requires a special diet due to medical issues, religious beliefs, and so on, necessitating the purchase of special food items	<input type="checkbox"/> Child/NMD requires modified home environment to accommodate his/her needs (severe food allergies, and so on) **Please note if the modification(s) is/are "one time" or on an "ongoing" basis. <input type="checkbox"/> Child/NMD has specialized needs (<i>example:</i> has a medically fragile diagnosis, has a low IQ, is developmentally delayed, smears feces, has separation anxiety, and so on) <input type="checkbox"/> Child/NMD with a severely compromised immune system requires universal precautions including a safe and sterile environment	<input type="checkbox"/> Child's/NMDs severe behavioral issues require intensive care, supervision and service provisions from the resource family to prevent STRTP placement <input type="checkbox"/> Child/NMD has recently transitioned out of STRTP placement; however, the child's/ NMDs behaviors continue to require intensive care, supervision and service provisions from the resource family to successfully transition/adjust and to prevent further STRTP placement <input type="checkbox"/> Child/NMD is at-risk of or is identified as a sex trafficked victim (CSEC) and exhibits behaviors such as recruiting, engaging in explicit photos/videos, chronic AWOL, over-sexualized behaviors, and so on, which require intensive care, supervision and service provisions from the resource family <input type="checkbox"/> Child/NMD has a terminal/ progressive illness or is on hospice, and requires frequent medical treatment for end of life care <input type="checkbox"/> Child/NMD is dependent on medical equipment (<i>example:</i> G-tube, dialysis, PICC line, ventilator, oxygen machine, and/or tracheostomy tube, wheel chair dependent/non-ambulatory), requiring constant supervision and care from the resource family.

SCI SOCIAL WORKER'S COMMENTS:

APPROVALS: Original signatures are not required if a supervisor, manager or deputy director is forwarding an approved request via email, and indicates electronic approval on the form and in the email.

Placement Supervisor:		<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date:
Placement RM:		<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date:
Deputy Director:		<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date:

Instructions: Email the completed form to the SCI Unit at: SCIUnit@rivco.org

CWS/CMS Child Case #:	J #:	Today's Date:
Child's Name: (first, middle, last):		DOB:
SCI Social Worker's Name:		SCI Social Worker's Phone:

(insert resource parent's name)
 (insert name of resource parent's home)
 (insert street address)
 (insert city/state/zip code)

Dear (insert resource parent's name):

The purpose of this letter is to inform you of your Special Care Increment (SCI) outcome for (insert child's/NMD's name), who is in your care.

It has been determined (insert child's/NMD's name), does not qualify for a SCI at this time. However, should circumstances involving this child/NMD change, or you obtain other supporting documentation for reconsideration, please feel free to notify the child's/NMD's case carrying social worker and the Placement/SCI Unit social worker.

It has been determined (insert child's/NMD's name), does not qualify for an increase to his/her SCI at this time. However, should circumstances involving this child/NMD change, or you obtain other supporting documentation for reconsideration, please feel free to notify the child's/NMD's case carrying social worker and the Placement/SCI Unit social worker.

Your SCI assessment has been closed for (insert child's/NMD's name), as the necessary documentation was not received. However, should you obtain the required documentation please feel free to notify the child's/NMD's case carrying social worker and the Placement/SCI Unit social worker.

You have the right to appeal this decision. A brochure is enclosed with more information regarding your rights and how to initiate this process. Should you have any questions, please contact your SCI/Placement social worker:

Placement/SCI Unit Social Worker Name: (insert SCI worker's name)
 Placement/SCI Social Worker Telephone Number: (insert SCI worker's phone number)

Thank you,

Regional Manager- Child Adoptions and Placement Services
 Riverside County DPSS- Children's Services Division

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing before an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: Cash Aid CalFresh
 Child Care

While You Wait for a Hearing Decision for:

Welfare to Work:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

Cal-Leam:

- You cannot participate in the Cal-Leam Program if we told you we cannot serve you.
- We will only pay for Cal-Leam supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. (Welfare Code Sections 10850 and 10950.)

TO ASK FOR A HEARING:

- Fill out this page.
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- Send or take this page to:

OR

- Call toll free: 1-800-952-5253 or for hearing or speech impaired who use TDD, 1-800-952-8349.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

- Cash Aid CalFresh Medi-Cal
 Other (list) _____

Here's Why: _____

- If you need more space, check here and add a page.
- I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE RIGHTS WERE DENIED, CHANGED OR STOPPED

DATE PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE

SIGNATURE DATE

NAME OF PERSON COMPLETING THIS FORM PHONE NUMBER

- I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

NAME PHONE NUMBER

STREET ADDRESS

CITY STATE ZIP CODE